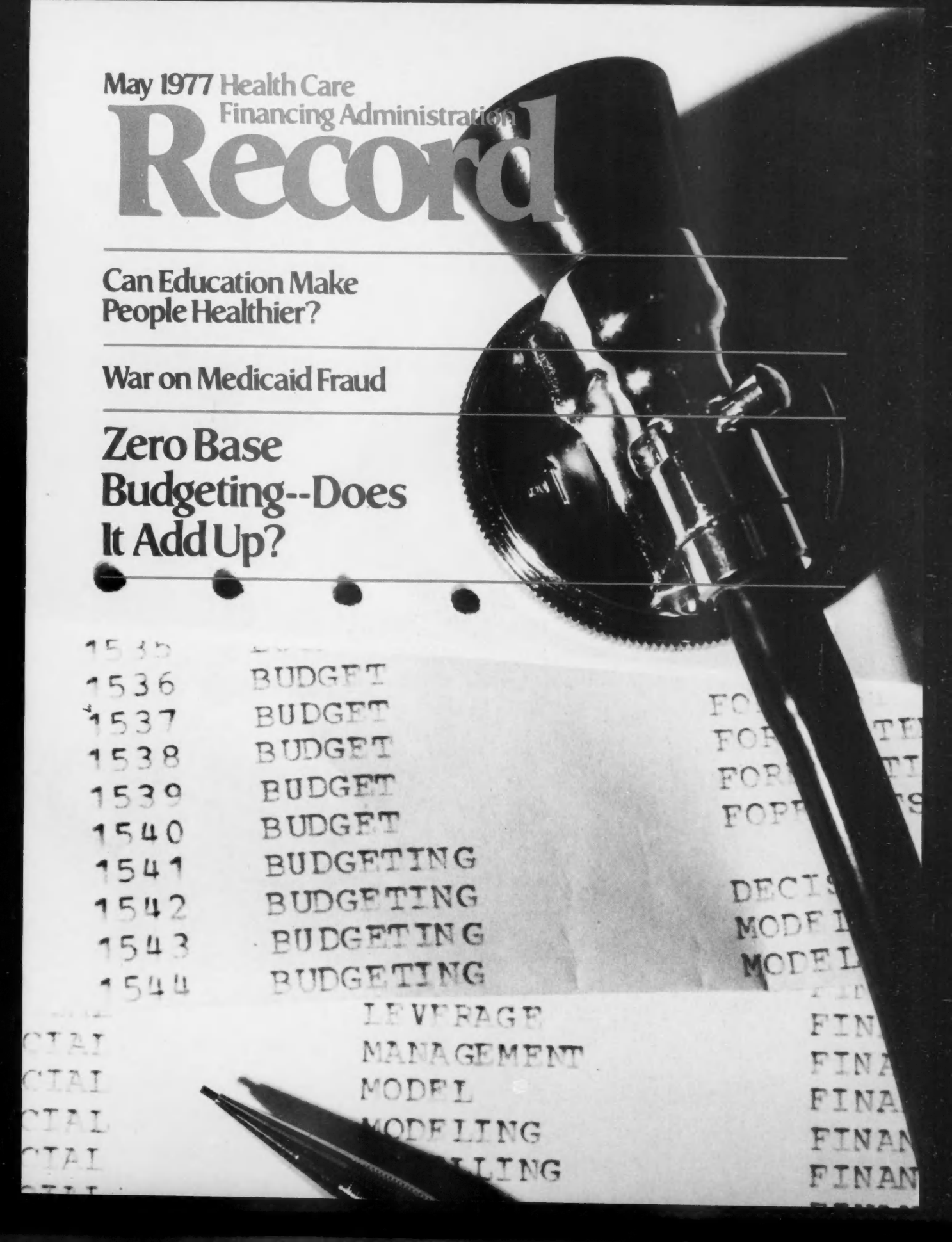
May 1977 Health Care Financing Administration

# Record

## Can Education Make People Healthier?

## War on Medicaid Fraud

## Zero Base Budgeting--Does It Add Up?



# "Where Does My Money Go?"

Find out how to get your money together in your own budget. Find out how to keep track of where your money comes from and where it goes.
Check it out with your local social services agency.
(A "supportive service" under WIN)

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# Record

Volume 1, Number 2 • May 1977

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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**The opinions expressed in this magazine do not necessarily reflect the views and opinions of SRS or HEW.**

## For the Record

The reorganization of HEW, which reassigned all SRS units to other agencies, has also changed the mission of the *Record*.

The new mission of this magazine is to support the objectives of the Health Care Financing Administration—the agency which was created to administer the Medicaid and Medicare programs and other health care units.

Although we will continue to publish articles on social services and Aid to Families with Dependent Children, the *Record* will begin to emphasize coverage of health care subjects as the transition of SRS units to other agencies progresses.

Social services are involved in the whole gamut of health care from investigating suspected cases of child abuse to helping maintain the mental well-being of nursing home patients. AFDC is linked with health care because those receiving AFDC are automatically eligible for Medicaid.

Health care is certain to be one of the most demanding issues of the next few years. There are already many opinions on what the nation's health care goals should be and how they should be achieved. As a national policy is hammered out on the anvil of public opinion and private necessity, the *Record* will report on the issues surrounding health care and progress in the various aspects of the field. And your subscription will continue without interruption.

Martin Judge

# Can Education Make People Healthier?

by Don Kent

Clearly the answer is yes. But how much healthier, and at what cost? How could it affect the 25 million Medicaid and 25 million Medicare users? Would they be healthier or manage their health care needs more efficiently — and more economically — if they received some training in prevention and maintenance of good health?

One of the most significant recent developments on the American health scene has been the emergence of a wide variety of self-care and health awareness programs. They developed from older, narrower programs for coping with specific diseases, usually chronic ones.

Today, laymen are frequently learning tasks traditionally performed by health professionals. Average citizens are studying ways of using health resources more efficiently and appropriately. They are learning to adjust their diets, lifestyles and behavior to achieve and maintain better health.

Some observers see the new trend as a partial alternative to professional care — particularly physician care — or as a way of avoiding inappropriate treatment. They expect it to result in better care and/or reduced costs.

On the economics of self-help, Professor Eli Ginzberg of Columbia University says: "Programing the American people to do much more about their own health would be a lot more economical and effective in easing the demands on physicians than producing more of them. This is an immense, untapped health manpower resource."

In an attempt to determine if health

education and health promotion are feasible for Medicaid and Medicare recipients, HEW turned in 1975 to Georgetown University's newly established Center for Continuing Health Education. HEW wanted an already-developed, field-tested program. Dr. Keith W. Sehnert, director of the center, had been giving his "Course for Activated Patients" in other settings for about five years. Dr. Sehnert adapted the course for use with a group of 20 Medicaid recipients living in a public housing development in inner-city Washington and for a group of Medicare beneficiaries of similar size living in the comfortable suburb of Reston, Virginia.

**The training program**

A major feature of this project was that the results of the 16-week course would be evaluated by comparing the behavior of those having taken it with groups of similar composition which did not.

In twice-weekly two-hour sessions the Medicaid and Medicare groups covered essentially the same terrain:

- Concepts of prevention and self-help.
- Medicines.
- Use of the health system.
- Medical skills and vital signs.
- Medical emergencies.
- Common illnesses.
- Common conditions.
- Common injuries.
- Oral-dental health.
- Nutrition.
- Alcoholism and drug abuse.
- Mental health.

Physicians, nurses, pharmacists and other health care providers were instructors for the course. They used similar course guides, one tailored to the interests and levels of senior citizens, the other to Medicaid recipients.

Participants were shown how to use a set of checklists and diagrams (called clinical algorithms) to determine when to see a professional and when to apply a well-defined home treatment. The charts cover common illnesses, injuries and emergencies.

To increase the participants' self-confidence in their relationships with physicians and other health care providers and in caring for themselves, they were each given a "black

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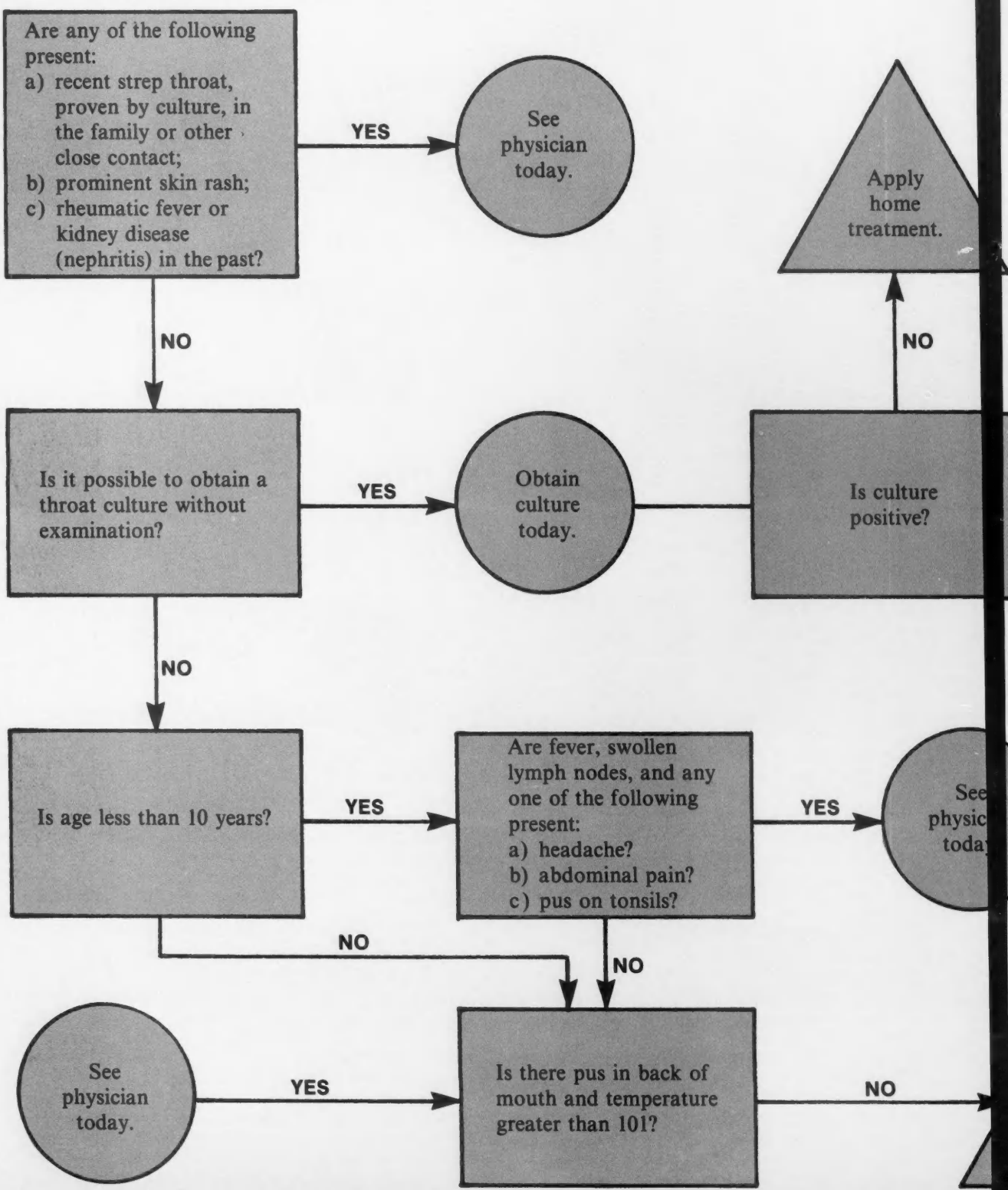
*Don Kent, who has observed health care delivery systems in Europe and Africa, as well as in the U.S., is a regular contributor to the* Record.


Are any of the following present:
a) recent strep throat, proven by culture, in the family or other close contact;
b) prominent skin rash;
c) rheumatic fever or kidney disease (nephritis) in the past?
YES
See physician today.
NO
Is it possible to obtain a throat culture without examination?
YES
Obtain culture today.
Is culture positive?
NO
Apply home treatment.
NO
Is age less than 10 years?
YES
Are fever, swollen lymph nodes, and any one of the following present:
a) headache?
b) abdominal pain?
c) pus on tonsils?
YES
See physic toda
NO
NO
See physician today.
YES
Is there pus in back of mouth and temperature greater than 101?
NO



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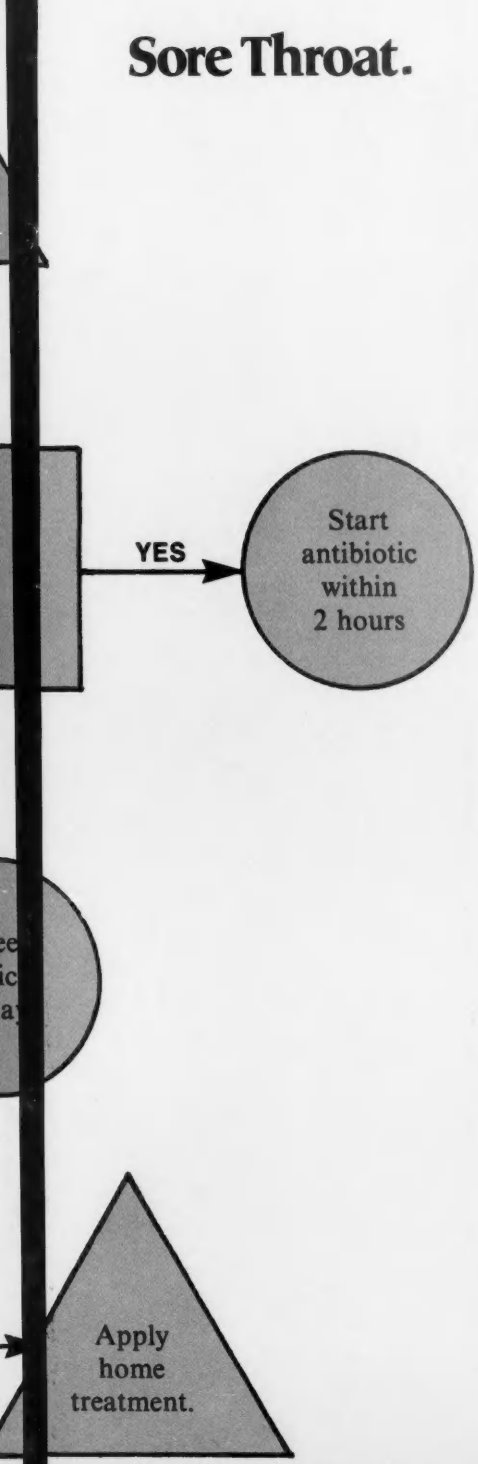



bag" containing some of the equipment physicians usually carry. Using this equipment, they were taught a number of health care skills such as taking blood pressure, temperature and pulse, and measuring respiration rates.

For six months following the completion of the two courses, the impact on participants was measured in terms of changes in health costs (e.g., doctor visits, tests and lab fees, and drugs) and the appropriateness of the use made of the health resource (e.g., emergency rooms, doctors' offices, medications, hospital visits). Also measured were changes in the participants' health behavior, health habits, confidence about self-care, satisfaction with professional services, and skills in detecting, observing and describing common health problems.

The HEW contract called for the course to be given at a second site. Minneapolis was chosen, because of its interest, and the city's health department sponsored and helped carry out a shorter version for senior citizens with limited evaluation.

Although the evaluation showed mixed results on cost-related questions, there were some positive effects on the health habits of the participants in both objective and subjective terms.

**Results of the course**

The groups taking the course not only scored significantly higher than the control groups but they achieved these higher levels consistently. This evaluation was made on the basis of questionnaires designed to measure health knowledge, confidence, appropriateness of self-care interventions and other points.

Both Medicare and Medicaid participants in the course scored much higher in effective use of professional health resources than their corresponding control groups. In one test, Medicaid recipients who took the course used professional care inappropriately only 6.5 percent of the time in the six-month period following the course, whereas the Medicaid control group registered 21 percent inappropriate use.

In another test, Medicare course participants used professional care inappropriately 4.8 percent of the time, whereas their control group registered 10.5 percent inappropriate use.

When appropriateness of self-care was measured, the Medicaid control group took inappropriate measures 67 percent of the time, whereas those taking the Medicaid course acted inappropriately in only 7.7 percent of their self-care efforts. Medicare groups scored somewhat higher percentages of inappropriate self-care: 72.7 percent for the Medicare control group and 17.3 percent for the Medicare beneficiaries taking the course.

Both Medicaid and Medicare groups taking the course were much more willing to receive care from professionals with a variety of levels of training, seemingly as a result of the course, whereas the control group remained highly physician-oriented.

In another experiment, two groups were tested before they took a course on measuring the characteristics of desirable lifestyles, mainly diet. Medi-

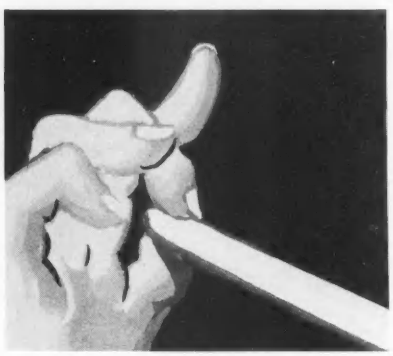
care participants scored a 74.8 lifestyle rating before taking the course. After the course, they scored 83.7. Medicaid participants were rated at 78.2 after the course, compared with 62.1 before the course.

Both groups taking the course showed appreciable progress in using selected clinical skills accurately. Medicare participants scored an average of 68.9 in such skills as taking temperature or pulse, compared with 55.2 for their control group. Medicaid participants scored 69.3, compared with a control group rating of 43.4.

An encouraging note for health

care professionals can be found in the evaluation of the course's effects on the patient-provider relationship. In the post-course period, 76 percent of the Medicaid participants said they were very satisfied or satisfied with the professional services they received, 15 percent were neutral on this subject and nine percent were dissatisfied or very dissatisfied. Of the Medicaid control group, 48 percent were very satisfied or satisfied, 14 percent neutral and 38 percent dissatisfied.

No consistent pattern of utilization and costs of drugs and labs emerged from the Medicare groups which took the course and control groups, possibly because the followup was done during six winter and spring months when incidence of illness and injury is



high. The number of primary care visits rose for both experimental and control Medicare groups.

The Medicaid followup on use and costs was done in summer and fall of 1976, possibly avoiding the problems that adversely affected the Medicare groups. Drug and lab costs and number of primary care visits went down for the Medicaid groups which took the course and up for the control group.

No attempt was made to measure any cost savings or improvement in care against costs of administering the courses.

In short, the study indicated that education should change Medicaid and Medicare users' health behavior but there was less indication of how it might affect health care costs. It broke new ground in showing how such education could be specially tailored to the needs of Medicaid and Medicare groups and in attempting to measure behavioral change.

The basic Georgetown course also

provided a pattern for courses given in New York, Virginia, Wyoming, Idaho, Utah, Maine and North Carolina.

**Health education increasing**

Many other approaches to health education are also developing across the United States. A recent HEW-commissioned study by Arthur D. Little, Inc., surveyed a wide variety of programs in many different settings, with self-care as only one of the programs. The report describes most of the comprehensive self-care programs as still in their infancy but sees them as a new trend toward multiple-focus programs encompassing self-diagnosis, self-screening and self-treatment. It foresees major significance in the emergence of the patient checklists and diagrams for medical decisionmaking, used in many of the self-care programs. If proven effective and used widely, they could have important implications for reducing the pressure on outpatient care and medical manpower, says the Arthur D. Little study.

The study also notes that programs on how to use the health care delivery system efficiently and appropriately are being given or developed by HMOs, hospitals, unions, public health departments and rural groups. In some cases, these educational programs brought about changes in the structure of the delivery systems, as problems were pointed out.

Another broad area of patient health education surveyed by Arthur D. Little was hospital programs. In a sample of hospitals studied, inpatient and community (outreach) programs were more frequent than outpatient programs. The most popular subjects for hospital-based courses are hypertension, diabetes and nutrition.

Many of the hospital-based courses give special emphasis to patients following the instructions of physicians — an area where many of the greatest gaps in treatment occur. For example, less than 10 percent of all diabetic patients observed in a recent Rochester School of Medicine study were carrying out a minimal regimen in the four areas prescribed for day-to-day management of their diabetes. A study of patients with congestive heart failure found slightly more than half took their medication as prescribed. Patient compliance with medication instructions averaged about 50 percent, with a high variance.

The need for consumer health care education increases in a still-undetermined ratio to the expansion of health care delivery itself.

Other excellent programs exist, but the general field of consumer health education is scattered, uneven, still lacking in clear-cut goals, methodology and evaluation procedures, and certainly in objective measures of their outcome.

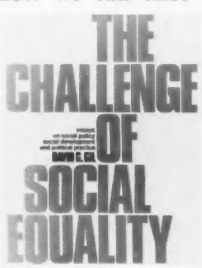
The HEW demonstration project with Medicaid and Medicare users was a limited but innovative step. Carrying such efforts further to a point of realizing their potential impact on the nation's health care programs may be one of the brightest challenges of the years ahead. ■

# Publications and Films

*Please address all inquiries and Requests for publications and films to the addresses in the listings. Items for review should be sent to Wilma Chinn in care of* The Record.

**The Challenge of Social Equality. Essays on Social Policy, Social Development, and Political Practice.** David G. Gill. Schenkman Publishing Co., 3 Mt. Auburn Place, Cambridge, Massachusetts 02138.

This volume is a new approach to the question of how we can effectively work for real social equality with genuine individual liberty.




The following themes are explored in essays:

- The nature, dynamics, and evolution of social policies, social orders, policy-relevant value-dimensions, and social development; and, related to this, dilemmas of social change and time.
- The systemic roots and dynamics of specific social problems, and, related to this, contradictions and dilemmas of social control versus human welfare, amelioration versus primary prevention, and reform versus revolution.
- Political practice aimed at overcoming current trends that threaten human survival, by transforming existing self-centered, inegalitarian, problem-ridden social orders and nation-States all over the globe into pacific, free, self-directing, humanistic communities which cooperate with one another on egalitarian terms on local, regional, and worldwide levels.

**The Effective Parent.** *Parents' Magazine* Films, Inc., Dept. A 46, 52 Vanderbilt Avenue, New York 10017. Sound and color filmstrip. Individual set $53 with records, $58 with cassettes. Set of four $180 with records, $200 with cassettes.

This filmstrip series presents suggestions for making everyday situations learning experiences for the young child, while pointing out how these activities help a child develop his or her own self-concept. The four sets are:

- The Parent As A Teacher, explains the importance in guiding the young child's first learning experiences and his feelings of pride and security.
- Learning In The Home, shows how caregivers can help their children develop intellectually and emotionally as they go about their daily activities. in the home.
- Learning Away From Home, discusses other activities that make children more aware of their world, introduces new concepts and open up learning experiences.
- Learning Through Play shows how the child's development is aided through toys, games and play experiences.

This series is designed for use by parents, young adults contemplating parenthood, teachers, paraprofessionals, community and social service organizations, and other groups and professionals concerned with young children and their families.

Each set includes five 35mm filmstrips, one LP record or three cassettes, five audio script booklets and one discussion guide.

**One-Parent Families.** Public Affairs Committee, 381 Park Avenue South, New York 10016. 50 cents. (No. 543)

This booklet discusses many of the problems of single parents and their children, offers suggestions for easing tensions in a variety of single-parent family situations, and lists agencies where the single parent can turn for help. Areas covered are difficulties of the single working mother, the single father, child care, dating, grieving, shared custody, desertion, single parenthood by choice, and children's feelings.

**A Consumer's Guide to Taking Over Health Planning.** Ted Bogue and Sidney M. Wolfe, M.D. Public Citizens Health Research Group. 2000 P Street, N.W., Washington, D.C. 20046. $2.35.

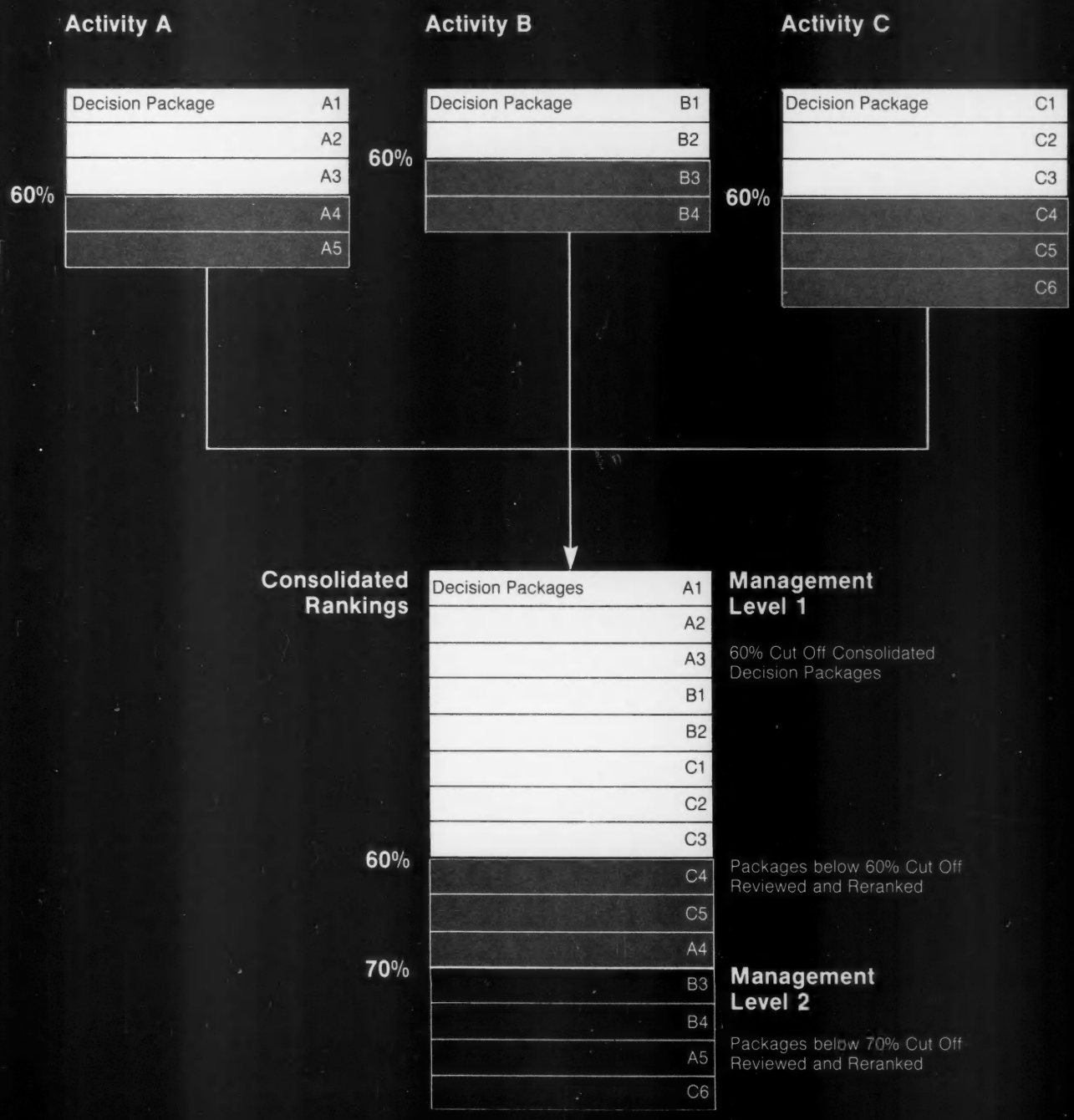
Suggestions for consumer involvement and guidelines for action are included along with a list of 200 local area planning agencies which have been established in most States.

**The Journal of Applied Social Sciences** (Winter 1977). School of Applied Social Sciences, Case Western Reserve University, Cleveland 44106.

The five articles in this journal represent a wide spectrum of subjects. They are:

- An analysis of the conflicting moral alternatives that underlie various policy approaches to affirmative action and preferential hiring. This analysis points out options that we may have overlooked in relation to overcoming racism.
- An analysis of the problem of child abuse that weaves together many of the complex social and psychological facets of child abuse and relates them to a specific program designed to ameliorate the problem.
- A highly personal road map through the twists and turns of social work practice over the past 25 years that concludes with a note of sobering realism that is tinged with optimism about the future of social work.
- An analysis of the policy implications of providing financial incentives to the children of elderly parents as a means of inducing them to care for their parents in their homes.
- The findings of a study on elderly residents' perception of their care in an institution. This article highlights the importance of considering the subjective views of the elderly rather than depending exclusively on professional opinion.

# Ranking and Consolidating Decision Packages



# Zero-Base Budgeting.

## . . . Much more than a buzz word.

by Victor Kugajevsky

The new buzz word that is forcing managers to: (1) dig into old files and determine how they justified an activity five years ago; and (2) study how the scene has changed since then is ZBB — zero-base budgeting.

It is receiving so much attention today because many experts say ZBB can increase an organization's resources from 15 to 30 percent without increasing the budget. Dozens of private firms — Xerox, Texas Instruments, Ford Motor Co., etc. — have used ZBB and found it cuts costs and raises profits by 10 to 20 percent.

The potential payoffs of ZBB are:

- Controlled budget growth.
- Clear identification of priorities — those funded and those not.
- Better targeting of resources.
- Funding new priorities from resource reallocations.
- Structured search for improved efficiency and productivity.
- Accountability for outputs and inputs.
- Rational and participative budget formulation.

Perhaps more than any other government activity, health and welfare programs are feeling the pressure of continuously expanding demands for service, rising costs and shrinking revenues. To make matters worse, efficient management of health and welfare programs is not commonplace.

Because most States administer many of these programs from the same administrative unit, we will look at the potential role of ZBB in both areas. Before doing this, however, it is useful to look at the situation in health and welfare programs today. H. Mahler of the World Health Organization estimates that if every American were provided with the full range of health services which current technology can deliver, the costs would exceed the nation's gross national product. In health programs the combination of open-ended "cost plus" Federal financing of Medicare and Medicaid, together with the continuing output of new and expensive technology (e.g. CAT scanners) and the infinite demand for better health care, guarantee an ever-escalating cost curve for health expenditures (at present rates they would double every five years). Add to this less than adequate administration, fragmentation and other factors and you get a health care system which is costly, inefficient and unable to consistently deliver a high quality product or service at an affordable price. Examples of efficient consumer measures rarely used by the hospital industry are group-purchasing, shared services, and general productivity management and optimum bed utilization techniques.

The nation's welfare programs, such as Aid to Families with Dependent Children and Food Stamps are in somewhat better shape but far from being efficient. While ZBB can help solve many of the problems which contribute to the poor administration of welfare programs, one problem stands out as the most easily solvable: program priorities which are seldom clearly chosen and left fixed long enough to make any significant progress.

### Traditional budgeting vs. ZBB

ZBB forces managers to examine carefully the fiscal rationale behind the whole program or activity. Traditionally, last year's budget base is never questioned. It is assumed that when funds were provided the rationale was sound or funds would not have been allocated. In addition, it is assumed that the circumstances which necessitated this program have not changed. Therefore, if a program had a $10 million budget last year, when it comes up for review it almost automatically gets a $10 million base for next year.

Budget review tends to focus on additions to last year's base and requests to fund new programs. Thus, much of what passes for budgeting is

*Victor Kugajevsky is director of the Office of Special Initiatives.*

merely a calculation of the amounts to be added to last year's budget. Instead of using the budget as a tool for planning and executing objectives, traditional budgeting is mainly a process of adding or subtracting from last year's spending level to balance next year's spending with available revenues.

Under the traditional budget review process the choice was to accept, reject or arbitrarily modify the request; the budget reviewer was effectively denied the option of trading off a requested increase in one activity against a reduction in another. A good budgeting system should give decision-makers options together with the best possible description of the cost and consequences of each option. Zero-base budgeting provides precisely these capabilities in a way that no other budget planning system can.

This is because there are several procedural shortcomings in traditional budget systems — the uncritical acceptance of last year's program activities, the inadequacy of the information developed; the lack of comprehensive analysis; and the inability to divide spending options. ZBB, on the other hand:

- Shows policymakers clear expenditure options and the consequences of selecting one rather than another. (See opposite illustration.)
- Uncovers low priority activities and shows the consequences of reducing or eliminating them.
- Lists programs or activities in a clearly discernible order of importance. (See illustration on first page of article.)
- Lays out alternative methods of doing things and alternative levels at which they may be done.

**The decision package**

The heart of the ZBB process is the "decision package." (See example on following page). This is usually a single-page document which describes a program activity in terms of: (1) purpose; (2) method of performing the activity; (3) alternative methods; (4) consequences of not performing the activity; (5) measures of performance and outputs; and (6) costs and benefits.

The decision package is prepared by the manager of the unit or function which is described in the package — this is where the "participative" aspect of ZBB occurs. Program managers, normally quite divorced from budgeting, get involved on the ground floor in building a ZBB budget. The purpose of the decision package is to force the program manager to critically examine the operations he is responsible for in terms of:

- Services to be delivered at different expenditure levels.
- Alternatives to "business as usual."
- Important results, impacts, benefits of his activity.
- Results of closing the shop — who gets hurt, how.

The decision package is the manager's concise statement of what he is in business for, what he hopes to achieve, how, and at what cost. Let's look at how a decision package fits into the ZBB process.

**The ZBB process**

The ZBB process normally consists of five steps: designating the budget units (cost centers) for which decision packages will be developed, ranking the decision packages in order of importance, consolidating the decision packages and preparing a traditional budget.

■ *Designating the decision unit.* This is normally the lowest level or cost center of an organization for which a set of decision packages and a budget are prepared. An important rule is that each decision unit must have an identifiable manager with the authority to establish priorities and allocate resources. Decision units usually follow the responsibility structure in an organization.

■ *Formulating the decision packages.* Managers prepare analyses of their activities stressing: (1) different methods of performing a function (in order to find the best way); and (2) different levels of performing the function (in order to find the most efficient level).

Normally decision packages are prepared for three levels of expenditure (or service output). First, the "minimum level package" — a given percentage below last year's budget. Next, the "stand still package" — the same as last year's budget. Then, the "augmentation package" — an increase in last year's budget.

This process of budgeting at different levels of expenditure gives higher level managers a clear comparison of the results vs. costs of various expenditure levels.

■ *Ranking the decision packages.* Each manager ranks his decision packages in decreasing order of importance. For example, a program benefiting only 25,000 persons might be given a low ranking when compared to a program benefiting 50,000 persons. However, a program benefiting 1,000 persons — if it is their sole source of assistance — might receive a very high ranking. For example, a manager's total budget this year is $100 million and he is asked to rank all of his packages so they total only $20 million. He does this and passes his consolidated ranking up to the next level for review plus those decision packages which didn't make his dollar cut-off.

■ *Consolidating the decision packages.* As the decision packages are passed up the organization ladder from one level to another, they are further consolidated at each level. The result is that each progressively higher level of management closely reviews a list of packages which are ranked in descending order of importance and a list of the packages that failed to make the dollar cut-off point.

This approach of ranking and consolidating packages at successively higher expenditure cut-off points forces managers to perform what

## Simplified Example of a ZBB Analysis of an Ambulance Service

| Resources Added to the Budget at Each Level* | Added Cost at Each Level | Cumulative Cost | Consequences of Added Resources |
|---|---|---|---|
| **Level 1**<br>One ambulance manned around the clock, 365 days per year (police respond to all calls to assist driver).<br>*Cost Items:*<br>• Salaries and fringe benefits of 4 drivers (4 are required for full protection).<br>• Annual vehicle operating costs. | $44,600 | $ 44,600 | **Minimal quantity and quality of service.**<br>• Average response time. 8 minutes<br>• Average time for arrival at hospital. 22 minutes<br>• Possibility exists that no unit would be available at certain times because it is already on call. |
| **Level 2**<br>A second ambulance unit. Same manning schedules as level one (police respond to all calls to assist driver).<br>*Cost Items:*<br>• Salaries and fringe benefits of 4 more drivers.<br>• Annual costs of operating second vehicle. | $44,300** | $ 88,900 | **Improved quantity and same quality service.**<br>• Average response time. 5 minutes<br>• Average time for arrival at hospital. 16 minutes<br>• Very slight possibility that both units would be in use at same time and no unit available. |
| **Level 3**<br>To each unit add a trained medic available around the clock 365 days per year (police need no longer respond).<br>*Cost Items:*<br>• Salaries and fringe benefits of 8 medics. | $96,000 | $184,900 | **Same quantity but better quality of service.**<br>• Average response time. 5 minutes<br>• Average time for arrival at hospital. 16 minutes<br>• Improved service quality may reduce complications among those requiring emergency vehicle. |
| **Level 4**<br>A third driver/medic and ambulance unit manned around the clock, 365 days per year.<br>*Cost Items:*<br>• Salaries and fringe benefits of 4 more drivers and 4 more medics.<br>• Annualized costs of operating a third vehicle. | $92,200 | $277,100 | **Improved quantity of service; same quality.**<br>• Average response time. 3.5 minutes<br>• Average time for arrival at hospital. 13 minutes<br>• Virtually no chance of a unit being unavailable. |

* Assumes use of police/fire radio dispatch system at no extra cost as well as free use of pace in existing firehouses or the general hospital.

** Less than amount shown in Level 1 because of reduced average running time and consequent reduction in average maintenance cost with two units operating instead of one.

## Decision Package Example

Manager _____ Prepared by _____ Date _____

| 1. **Function:** Fraud and Abuse | 2. **Agency:** HCFA/MSA | 3. **Rank:** 2 |
|---|---|---|

4. **Objective:** To conduct reviews of Medicaid providers in order to achieve claims reimbursement integrity

5. **Method of Performance:** Conduct field investigations and audits of samples of provider claims to determine validity: 10 States scheduled for audits and field reviews.

6. **Expected Results:** Identification of level of probable fraud and abuse in each State Medicaid Program; estimate of dollar loss; profile of abuse patterns and providers. Reports and documentation for follow-up action by State (provider review, dismissal, prosecution, etc.).

7. **Consequences of Not Approving:** Public criticism of inaction; continued absence of fraud and abuse controls in Medicaid; continued dollar loss from unchecked abuses.

| 8. **Quantitative Measures** | **FY '77** | **FY '78** | 10. **Resources Required (Dollars in thousands)** | **FY '77** | **FY '78** | **%FY '78/77** |
|---|---|---|---|---|---|---|
| Claims reviewed | 500 | 2000 | Personnel Operations | $150 | 1250 | 500% |
| Providers audited | 100 | 500 | Lease rentals | | | |
| | | | Capital outlay | | | |
| | | | Total | | | |
| | | | People (positions) | 100 | 250 | 250% |

## Consolidation Summary

| | | FY'76 Amount | | FY'77 Amount | | Cumulative Level | | |
|---|---|---|---|---|---|---|---|---|
| | **Package Ranking** | **Funds** | **Positions** | **Funds** | **Positions** | **Funds** | **% '77/76** | **Positions** |
| 1 | Administration (1 of 1) | 32,500 | 3 | 36,400 | 3 | 36,400 | 3.8 | 3 |
| 2 | Executive Admin. (1 of 1) | 26,200 | 1 | 32,400 | 1 | 68,820 | 7.2 | 4 |
| 3 | Grants MWSI (1 of 2) | 100,000 | 4 | 150,000 | 4 | 168,820 | 17.7 | 8 |
| 4 | Budget (1 of 3) | 55,500 | 2 | 55,500 | 2 | 224,320 | 23.5 | 10 |
| 5 | Fin. Mwst (1 of 3) | 155,875 | 19 | 132,493 | 17 | 356,813 | 37.4 | 27 |
| 6 | Program A (1 of 3) | 100,000 | 15 | 150,000 | 20 | 506,813 | 53.1 | 47 |
| 7 | Program B (1 of 3) | 400,000 | 20 | 450,000 | 22 | 956,813 | 100.1 | 69 |
| 8 | QC (1 of 3) | 50,000 | 15 | 50,000 | 12 | 1,006,813 | 100.5 | 81 |
| 9 | Grant Mngt. (2 of 2) | 25,000 | 5 | 30,000 | 5 | 1,036,813 | 100.9 | 86 |
| 10 | Budget (2 of 3) | | | 100,000 | 10 | 1,136,813 | 119.0 | 96 |
| 11 | QC (2 of 3) | | | 75,000 | 6 | 11,186,813 | 124.3 | 102 |
| 12 | QC (3 of 3) | | | 100,000 | 10 | 1,286,813 | 134.7 | 112 |
| 13 | Fin. Mngt. (2 of 3) | | | 50,000 | 5 | 1,336,813 | 139.9 | 117 |
| 14 | Training (1 of 2) | | | 150,000 | 10 | 1,486,813 | 155.7 | 127 |
| 15 | Fin. Mngt. (3 of 3) | | | 50,000 | 5 | 1,536,813 | 160.1 | 132 |
| 16 | Promotion (1 of 1) | | | 200,000 | 5 | 1,736,813 | | 137 |
| 17 | Training (2 of 2) | | | 50,000 | 5 | 1,786,813 | | 142 |
| | Total Pkgs. | 955,075 | 84 | | 142 | | | |

$$\frac{356,813}{955,075} = 37.4$$

economists call "marginal analysis" — at this given expenditure level is an increment in program A more important than an increment in Program B or is a program element of one more important than another. Thus the higher level manager can pull a decision package out of the consolidated ranking list and replace it with one or more of the packages that his subordinate placed outside the cut-off point. The benefit of this process is that the order of priorities within a program and among the programs is made crystal clear and the decisions about the order are made by the managers responsible for the entire agency. Some commonly used criteria for ranking decision packages and trading off one against another include:

- Impact of the package on public health and safety.
- Numbers of people who will benefit.
- Legislative requirements.
- Contribution to the objectives of the agency.

Once the decision packages have been ranked and consolidated into the ZBB summary and a decision made on next year's expenditure level, the ZBB budget is normally converted to the familiar object-class, line-item budget.

■ *Preparing the traditional budget.* The ZBB format is converted to the traditional object-class budget and operating work plans (if used) showing how the various program activities will be carried out. The ZBB format may also be linked to other management control systems such as operational work plan or production schedule.

One advantage to a budget in ZBB format is that it fully exposes the decisions of managers. For example, if a welfare agency presented its budget to its State legislature in ZBB form, the legislators could:

- Agree with the welfare administrator's recommendations.
- Shift some programs to higher service levels and lower others to free up required resources.
- Increase appropriations to expand services.

The process puts the welfare administrator and legislators in the enviable position of having meaningful expenditure options and knowing the consequences of each. If they are funding new service levels and are not funding existing levels, they are in a position to assess the relative merits of the programs presented by the agency. They can easily determine that the consequences of one level of service are more important than those derived from the next level. In addition a zero-base process requires that every piece of the budget be analyzed for its costs and benefits — not just high visibility programs.

**Stopping the game players**

When a ZBB system is implemented some precautions must be taken to prevent "gaming," the process by which a manager can illegitimately obtain both his low-priority and high-priority packages. A manager can do this by assigning high rankings to low-priority items and low ranking to high priority ones in the hope that upper management will quickly up-grade his low-priority packages and not down-grade his high-priority ones because they are not easily spotted in a consolidated list. Another ploy is to pad the "production function" in a particular decision package by claiming more resources than are actually required to produce a given output.

An audit system can discourage both types of gaming. Such an audit may include:

- Keeping trend lines on unit costs to spot unusual jumps in "production function" processes.
- Spot checking operations with work measurement audits.
- Installing internal labor productivity measurement indices (productivity base year/productivity current year).
- Sending in special management audit teams to uncover unusual rankings.
- Relying on judgements of seasoned program and budget people to spot low-priority packages hidden in a consolidated ranking list.

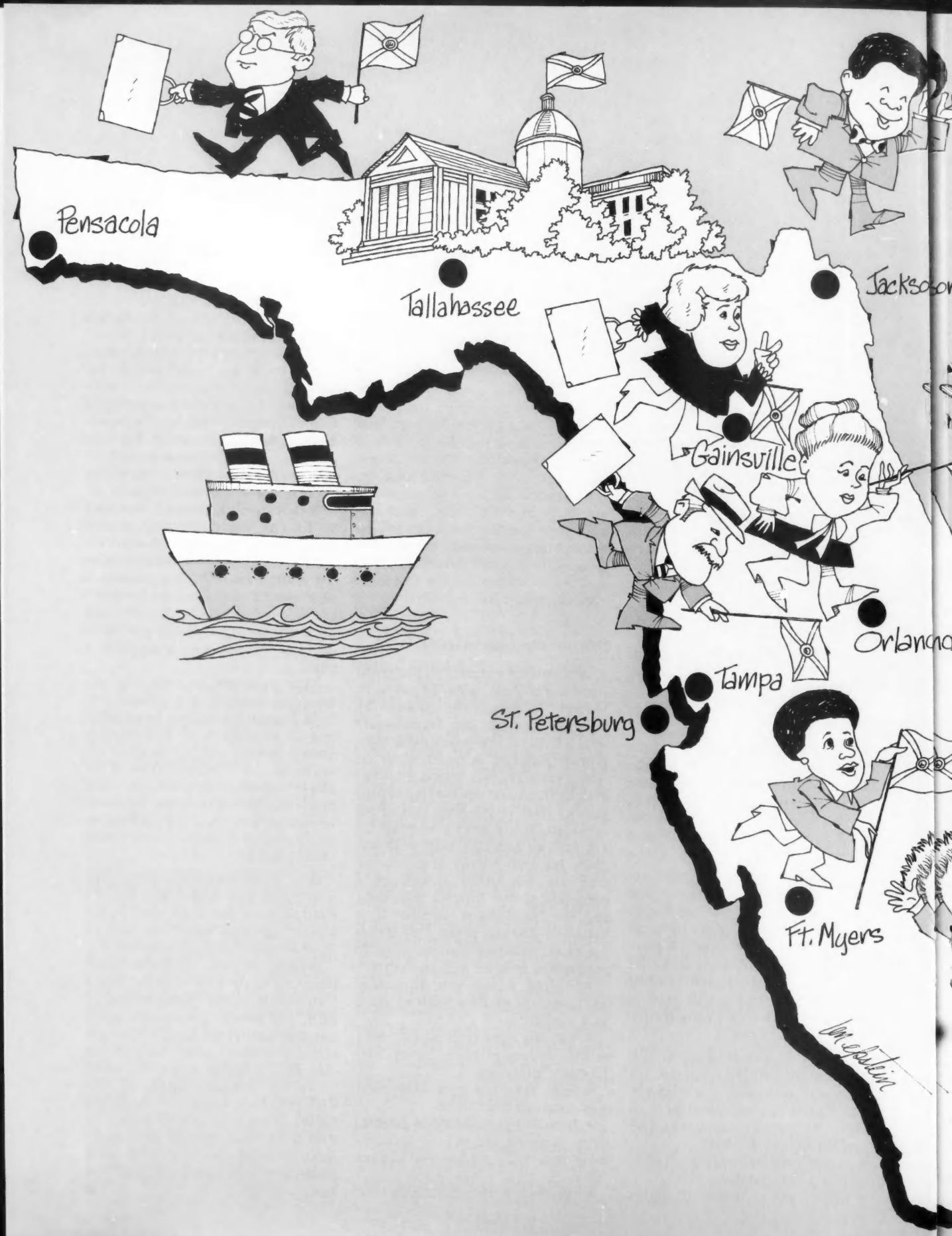
ZBB is not suited for every enterprise. It is not well suited, for example, to manufacturing operations nor to operations requiring a five- to 10-year "blind faith" commitment, such as basic research. Basically it is ideally suited to most activities in government programs, especially those in the human services area.

Although ZBB is readily modified to fit any organization, it usually takes two to three years before the system is fully operative. Implementing ZBB is an unsettling process. It displaces an established budget process. It forces an annual identity crisis on every manager. It can go out of control, producing an avalanche of paper.

Thus management must carefully weigh the decision on where and how to implement it and then be unremitting in its support of it. Otherwise implementation will fail. Some of the questions top management must ask about implementing ZBB are: how much of the organization to cover; how deep into it should ZBB reach; over what time period should it be implemented?

Once implemented, however, ZBB is an invaluable tool whose benefits multiply with increased use. Public welfare agencies would do well to carefully examine these benefits.

Indeed, the very favorable experience of companies, such as Texas Instruments, which pioneered use of ZBB, and several government agencies, particularly the State of Georgia under Governor Carter, have shown that ZBB is highly useful. President Carter is directing much of the Federal Government, including HEW, to prepare its next budget in ZBB form. Thus the Federal Government is committed to ZBB. Will States and local agencies follow? The choice is theirs. ■


Pensacola
Tallahassee
Gainsville
Tampa
St. Petersburg
Ft. Myers

**". . . In the past the recipient had to make the system work. Now the system works for the client."**

# How Florida Reorganized its Health and Rehabilitative Services.

by William J. Page, Jr.

Florida's health and social services delivery system in the early 1970s was known throughout the State as the "monster of all State bureaucracies." Key legislators felt that millions of the organization's $400 million annual budget were being drained as money sifted through the organization and they felt those in need were not receiving the benefit of the appropriations.

The tone at the opening of the State's annual session two years ago was a "massive onslaught" against government bureaucracy.

The onslaught resulted in the complete legislative reorganization of the Florida Department of Health and Rehabilitative Services together with some changes in other State agencies.

Only two other States have had integrated services before — Arizona and Georgia. Both, however, have changed somewhat from their original integrated status. Florida's reorganization is unique in that it was initiated by the legislature rather than the executive branch.

The key word in the reorganization became decentralization. Operations were decentralized to 11 districts — each a mini-department serving a specific geographic area with some including established institutions. Each district was designed to provide a comprehensive, integrated system of health, social, and rehabilitative services. Where 11 percent of the department's staff had been at headquarters, under the reorganization there was only six percent.

I wholeheartedly support localization of the system, but I suffer no illusion that decentralization, per se, saves administrative costs. Its contribution is to people in need.

Under the integrated department concept, central staff is responsible for planning, evlauation, coordination of budgeting, and staff allocations for program services. The legislature directed that the old divisional structure be abolished in favor of program offices responsible for statewide supervision of:

- Administration.
- Technical assistance and program planning.
- Monitoring.
- Evaluation.

The principal services for which the new district-based department is responsible are:

- Children's medical services.
- Medicaid.
- Public health programs.
- Aid to Families with Dependent

*William J. Page, Jr. is secretary of Florida's Department of Health and Rehabilitative Services.*

"The decentralized system is more responsive. It receives more and better influence from recipients. It provides more immediate knowledge."

Children.

- Food stamps and food distribution.
- Dependency, adoption, child care and foster care services.
- Youth services.
- Services for the retarded and those with developmental disabilities.
- Disability determination (Social Security).
- Mental health.
- Vocational rehabilitation.
- Aging and adult services.
- Eligibility determination for supplemental security income.

Adult corrections and blind services were transferred from the department. (Corrections became a separate department and blind services was transferred to the Department of Education.)

To operate under the new structure in 1976-77, the department was authorized staff of 28,239 and a budget of $998 million, of which some 54 percent came from the Federal Government.

**Greater availability of services**

To receive services under the old structure a recipient with multiple needs was likely to have had to go to five or six offices in two or three separate locations. Under the reorganized system a recipient with multiple needs goes to a local office and is referred to a case assignment manager. It is the responsibility of this manager to insure that the recipient receives as many of the department's services as he needs. In short, in the past the recipient had to make the system work. Now the system works for the client.

Each of the 11 district administrators, who are appointed by the secretary of HRS, in turn appoints a district manager for administrative services, program managers and program supervisors. These managers must create district programs that follow statewide objectives and policies.

To insure citizen and consumer access to human services managers, each district has an advisory council of citizens appointed by the Governor.

There also are human rights advocacy committees in each district with responsibility for protecting the constitutional and human rights of any client within a program or facility operated, funded or regulated by the department.

**New strings on the purse**

Decisions regarding control of the department's purse strings also were changed by the reorganization act. Under the former system, resources were allocated to the program divisions and within them to program activities. For example, the old Division of Youth Services budget was further passed down to development centers, training schools, detention centers, community programs and the like.

The flow of money is easier to follow under the reorganization because the budget is divided into four entities: Office of the Secretary, Assistant Secretary for Program Planning and Development, Assistant Secretary for Administrative Services, and Assistant Secretary for Operations, which incorporates the individual districts' budgets.

The budgeting process for a district includes substantial input from that district. But the districts do not have license to establish fiefdoms. In addition to stringent review of the basic proposal, factoring in such variables as whether or not the district is basically rural or urban, the HRS secretary has the power to approve and amend all budgets. He can also transfer up to five percent of an approved district's operating budget.

**Greater program integrity**

To insure uniformity of operation among the districts and to maintain the quality level of the programs, a system of monitoring and review was established along with a requirement for evaluating departmental programs.

The reorganization act mandates that "a comprehensive program evaluation system shall be established which shall encompass all major programs . . . The department shall establish measurable program objectives and performance criteria for each program it operates. Such a system of evaluation shall require all programs to develop identifiable goals which are quantifiable whenever practicable and to estimate the cost of attaining such goals in advance. Studies of the relative cost and effectiveness of departmental and alternative programs shall be conducted. The department shall develop a program evaluation schedule and shall evaluate at least 20 percent of its programs annually. The department shall submit these evaluation schedules and reports to the Secretary, who within 30 days of receipt shall transmit copies of the schedules and reports to the appropriate substantive committees of both houses of the legislature for review. When possible, the department's management information system shall provide the basic information for program evaluation studies."

Currently the department is evaluating more than 24 programs and expects to meet the statutory requirement on evaluation by the end of the current fiscal year. A key to compliance with the evaluation requirement has been, and will continue to be, the development of adequate information systems within the department.

Provision for development of a useful network of information systems was a high priority in the development of the 1977-78 budget. A full-scale management information system is being developed and implemented. This will include recipient, Medicaid and food stamp and other information systems. In addition a

"I wholeheartedly support localization of the system, but I suffer no illusion that decentralization, per se, saves administrative costs. Its contribution is to people in need."

federally-funded Vital Records Control System is being developed to reflect the needs of the general public for records of births, deaths and other vital data. HRS' prototype Food Stamp Information System currently is under study by the Department of Agriculture for possible national implementation.

**Emphasis on collocation**

In its first year of full operation, the department continues to collocate services throughout the districts. Twenty percent of the collocation work is completed and 75 percent of the lease work is under way. General planning has been done for the percentage awaiting expiration of existing leases.

It is believed that collocation is bringing a greater spirit of cooperation among professionals and others and, in turn, promises greater satisfaction from work. Yet, the problems of collocation are many, not the least of which is cost.

**Results of decentralization**

Decentralization, like reorganization, speaks more to effectiveness than to cost efficiency. For example, we had 10 principal personnel officers under the old system. Today, we have 11 district personnel officers and an overall department personnel officer.

The districts replicate the functions of headquarters. (Notice that I said replicate, not duplicate.) The decentralized system is more responsive. It receives more and better influence from recipients. It provides more immediate knowledge.

An example of the immediacy of response came with the winter freeze that had such a disastrous effect on Florida's migrant population. District administrators were at the scene of the disaster and were able to react more quickly than anyone in headquarters possibly could. Their personal involvement with a variety of other service agencies in their districts enables them to immediately draw on these resources to meet critical needs.

While the district setup has distinct advantages, it also produces conflicts. We are dealing with a classic proposition. You can organize according to functions, which in our case are programs, and you can reduce the static in the system. Or you can organize by geography with total authority out there in the districts and have nothing in the way of functional control and reduce the static that way. But that's not necessarily the best way to get optimum performance out of the system.

The conflicts at the intersection between functions and geographical structure will always be with us. The question is not whether they will occur but how well they are managed when they occur — or how well people cope with it.

That ability to cope with a changing organizational structure has been a problem experienced by virtually all employees at all levels. Some people seem to be coping with the system very well and some people, units and districts cope with it better than others. Some, of course, just don't cope at all. We are confident, however, that any kind of structure can be made to work if people will work together.

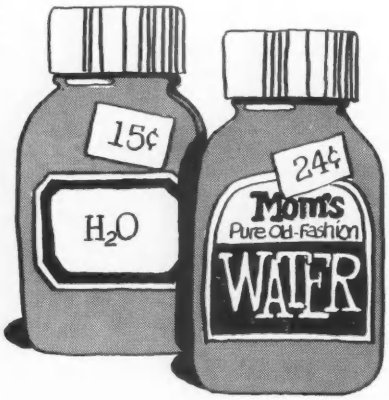
Employee placement statistics attest to the desire to make the new system work. Despite an estimated 1,800 adversely affected employees who were displaced from jobs by reorganization, all but seven were eventually placed in new jobs within the department. After exhaustive efforts to place the final seven failed, they were laid off in September.

It is felt that there is more worker satisfaction under the reorganization than existed before. They identify more readily with the district structure instead of feeling they are swallowed up in a bureaucratic maze. For example, I encountered a veteran worker at a district meeting in Miami recently and thought she was going to really tear into me about an issue. Instead, she said, "When I first learned about reorganization, my attitude was negative. I could just see the world disintegrating around me. I have worked in it, with it, around it every day, and I don't owe that system a nickel's worth of anything. But I want to tell you that I am convinced now that it is a far better thing than we had. I see the difference it makes in the way certain people work — people with whom I've worked for years — and how they're working with other people."

The major thrust of reorganization can be summarized in a few words. It has created a unified and improved management and structure, easier accessibility and responsiveness to the recipient and unified service delivery process. In obtaining these ends, the changes made in Florida have had a major impact on the proliferative Federal programs and the basic issues of the rights of the States. Intergovernmental issues and conflicts as well as increased cooperation are obvious results of the reorganized department.

Apart from problems of implementing Federal vocational rehabilitation program guidelines, designed for program control instead of our district control, I am optimistic that a precedent will be set even though we are working against overwhelming odds. (Editor's Note: HEW's Rehabilitation Services Administration has disapproved Florida's organization for vocational rehabilitation and the matter is under judicial review.)

On July 1 our department will enter its third year as an operating, integrated human services delivery system. We will continue to work diligently to achieve a model human services system — not as a static entity but as an organization capable of assessing and fulfilling the needs of our recipients. ■




## Generic drug use upheld for Medicaid/Medicare.

HEW's requirement that lower priced generic drugs be used in place of high-priced brand name counterparts was upheld by a Federal judge in Chicago.

U.S. District Court Judge Prentice H. Marshall dismissed a suit brought by the American Medical Association, the Pharmaceutical Manufacturers Association and five individual physicians.

The HEW regulations in question provide that when generic drugs of equal quality to brand name drugs are available, HEW programs will pay only the lower, generic cost.

## N.Y. closer to controlling Medicaid costs.

The New York State Department of Social Services has selected a contractor to help in the design, implementation and initial operation of its automated system for controlling the State's Medicaid program and its expenditures. The technique is called the Medicaid Management Information System.

The next step is negotiation of a contract which must be approved by the State's attorney general and comptroller. The first year of the contract will cost about $32 million, according to Social Services Commissioner Philip L. Toia.

In explaining the justification of the MMIS when development was begun last year, Mr. Toia pointed out that more than $3 billion was spent in the State to provide health care paid for by Medicaid.

Mr. Toia noted that 90 percent of the system's development costs will be reimbursed by HEW. The department will also pay 50 percent of the operating costs of the system until it approves the system operation. At that point, the Federal Government will pick up 75 percent of the operating costs.

The Medicaid Management Information System is being developed first in New York City, where most of the State's Medicaid claims originate, and where the system will begin operation. The first Medicaid claim is expected to be processed by the system in November.

## Dual MBA/MSW degrees to be offered by Penn.

A dual master of business administration and master of social work program will be offered by the University of Pennsylvania's Wharton School and the School of Social Work, effective with the 1977-78 academic year. The program was developed over two years under an HEW training grant.

The three-year program, leading to the dual degrees of MBA and MSW, is for a limited number of students interested in careers in management of social services.

Students will be independently admitted to both schools. Field placements will be in mid-management and administration developed to meet the educational needs of the students.

## Reimbursement dispute with Medicaid settled.

The dispute between officials of Illinois' Medicaid program and the State's hospitals over a new reimbursement policy has been settled through mutual agreement.

Following the State's announcement of a new reimbursement policy in October 1975, the Illinois Hospital Association filed a suit in U.S. District Court saying the new policy was unfair.

Significant features of the agreement include:

- The State will reimburse hospitals on the basis of the policy in effect prior to October 1975 for all Medicaid services provided.
- The State plan will be amended to permit automatic updating of reimbursement on the basis of cost reports from the hospitals. Hospitals will also be allowed to update their rates during the fiscal year — a practice halted during the moratorium of the past several months.
- For general assistance, a one time payment will be made to reflect the fact that rates were not updated from October 1975 through April 1977.
- The State will process hospital claims within 30 days of receipt.

## Record ANA certification of nurse practitioners.

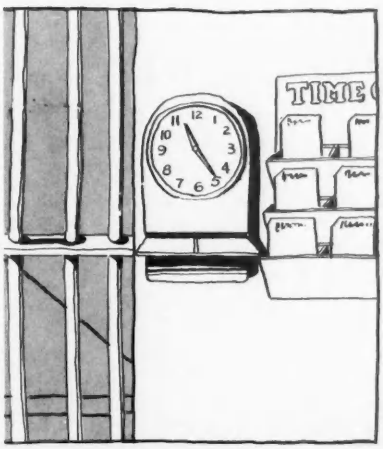
Some 559 adult and family nurse practitioners were recently certified by the American Nurses' Association. This is the largest single group to be certified by the association.

This action will have a significant impact on the delivery of health care services to those in rural areas, particularly if a Federal law is passed to reimburse rural health clinics for primary care services provided by nurse practitioners and clinical nurses.

Such a bill is currently under study in the Senate and House which would amend Title 18 of the Social Security Act.

Federal funds under Medicaid are

already available to any State where nurse practitioners are licensed and included in the State's Medicaid program.




## Welfare fraud draws jail term, restitution.

Four welfare recipients who were receiving assistance in both Illinois and Indiana have pleaded guilty to 198 counts of theft and public aid fraud totaling more than $24,500.

The dual payments were uncovered through the Illinois Department of Public Aid crossmatch program with Indiana.

The severest sentence handed down was a five-year felony probation with restitution plus one year of weekends in the house of corrections. In the other three cases sentences were limited to felony probation with restitution.

## Bronx podiatrist sentenced for Medicaid fraud.

A podiatrist employed at a Southeast Bronx Medicaid clinic has been sentenced to four years in jail for Medicaid fraud.

Evidence presented at the trial of Dr. Mark Buthorn, Jr., showed invoices for entire families who supposedly had received treatment, when in fact no such service was performed.

The doctor had previously been convicted of submitting invoices for Medicaid services which were never provided.

SRS staff assigned to the U.S. Attorney's Office assisted in preparation for the trial.

## Mass. combines services for abused/delinquent youth.

A single State agency to handle services for battered and delinquent children has been proposed by Massachusetts Governor Michael S. Dukakis.

The new agency would be created by merging the Department of Youth Services, which deals with juvenile delinquents, and the Office of Social Services, a part of the Welfare Department.

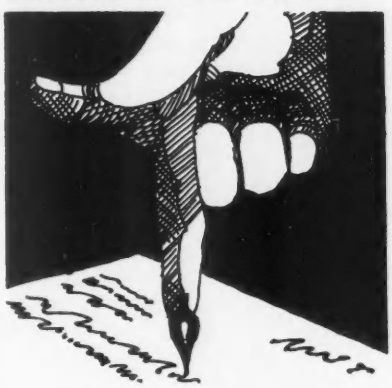
## Ky. reinstates AFDC-UC.

Kentucky has rescinded a directive terminating payments under the AFDC unemployed-father program.

An earlier decrease in the State's unemployment rate to 5.5 percent prompted the State to stop the payment. However, the severe winter caused many fathers of minor children to be laid off, resulting in an increase in the unemployment rate.

The State now plans to continue the program until the fall of this year, based on the unemployment rate for the first quarter and the anticipated lack of jobs for students during the summer.

# Letters to the Editor



## Nursing home moves arouse reader interest.

To the Editor:

Please provide me with further information regarding the system for relocating patients described in *The Record.*

J. J. Young
Chief Social Worker
Ministry of Health
Lakehead Psychiatric Hospital
Thunder Bay, Ontario

To the Editor:

The article entitled "Increased Sensitivity Lowers Death Rate in Nursing Home Moves" was very timely and appropriate for this State agency.

This agency is responsible for reviewing medical assistance patients in nursing homes. Periodically these elderly residents must be relocated to another home. Therefore, any additional information you may have available concerning this subject could be extremely helpful.

Steven Lamborghini
Administrator
Medical-Utilization Review
Nursing Home Program
Topeka, Kansas

To the Editor:

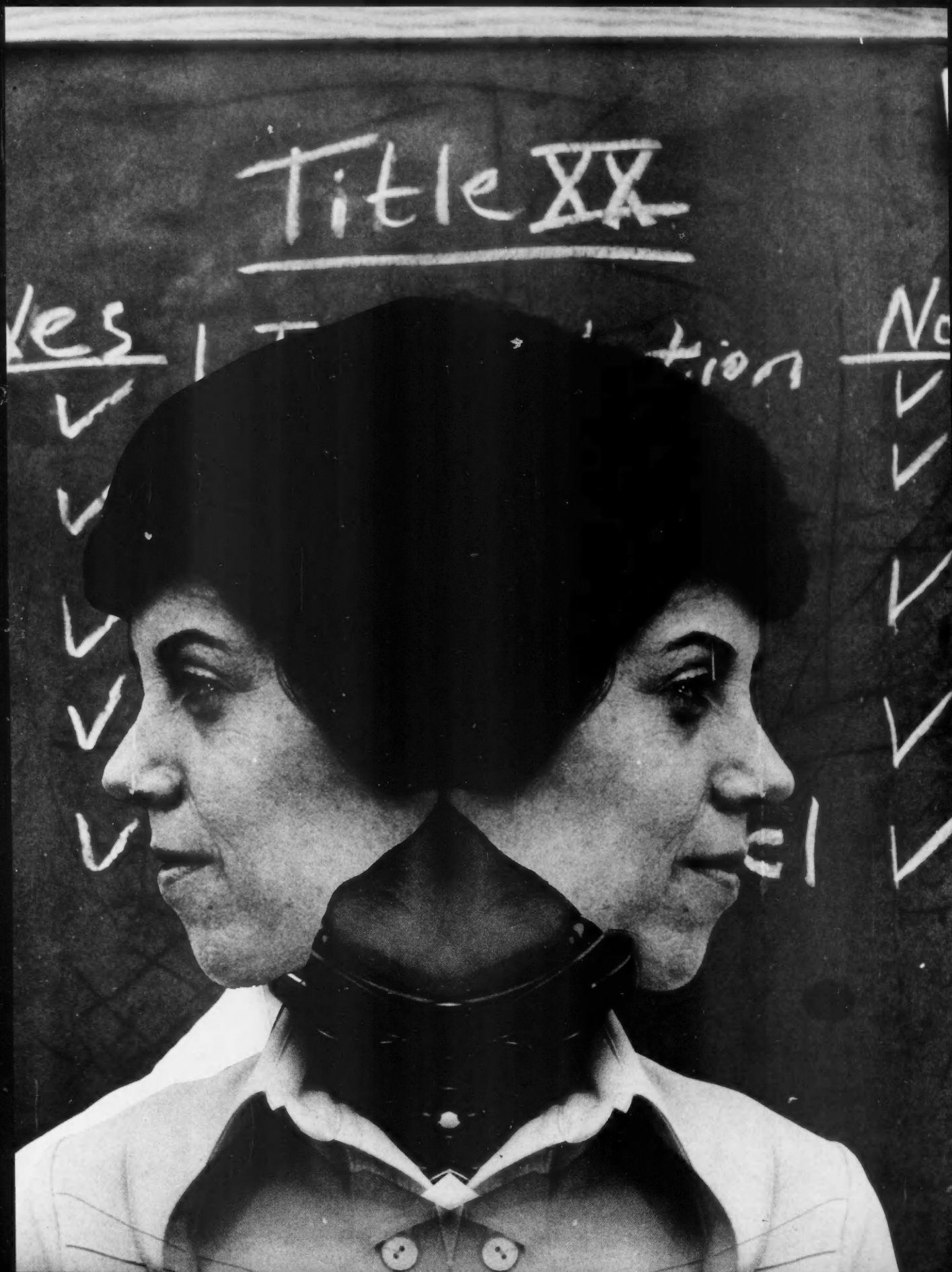
I am requesting further information on the nursing home relocation team which appeared in the *Record.*

Earl M. Bosier
Supervisor
Adult & Family Services Section
Department of Social Serivces
Denver

To the Editor:

I read with deep interest the article on "Increased Sensitivity Lowers Death Rate in Nursing Home Moves." I would appreciate receiving more information about the process.

Mary R. Johnston, R.N.
Assistant Director of Nursing (INST.)
Department of Public Health
Boston


Title XX

# The Dilemma of Enforcing Federal Day Care Requirements.

by William Darnell and Susan Jones

States receiving Federal funds for child day care services under Title XX of the Social Security Act are placing millions of dollars at risk if they disburse funds to facilities that do not comply with the Federal Interagency Day Care Requirements. Though these requirements were enacted eight years ago, to date they have not been fully enforced. The reason for this is as complex as the requirements have been controversial.

Controversy surrounding the day care requirements has focused almost exclusively on the staff-child ratio. A casual query into the issue might lead one to believe that this requirement is the sole barrier to effective enforcement. Not so, according to a study conducted in Region V States*. This study reveals that the problem of compliance reaches far beyond the controversy about the requirements themselves.

The requirements cover the broad spectrum of day care, with the staff-child ratio only one of its components. The nine major categories which the requirements cover are:

- Day care facilities.
- Environmental standards.
- Educational services.
- Social services.
- Health and nutrition services.
- Training of staff.
- Parent involvement.
- Administration and coordination.
- Evaluation.

None of these categories seem especially controversial or provocative. One might assume that any good day care program should operate according to similar standards. This assumption probably contributed to inclusion in the Title XX legislation of the requirement that day care services provided under that authority must meet the requirements. What are some of the major problems in complying with these requirements?

### Cost of compliance

Much of the controversy about the Federal requirements is related to the anticipated increase of costs, compared to their uncertain benefits. The study shows that the difference in cost to operate pre-school centers that meet the Federal staffing requirements and those that meet State standards is about two to three dollars a day per child.

Since child care is not a required service under Title XX, a State may choose to use other funding sources to support this service and avoid risk of financial sanctions. A day care center can avoid the higher cost of operation by simply not enrolling a child who receives Federal funding. Centers can also try to enroll only Title XX-subsidized children and charge a rate to support additional staff. However this would cause a problem in States that have a policy of restricting the number of day care center slots which can be purchased for Title XX-subsidized children.

Since higher rates cannot be charged in the same center for federally-subsidized children than for any other children, centers which take federally-subsidized children are often unable to compete in the private market. In many cases, the increased cost of meeting Federal requirements has resulted in a form of economic segregation.

Many centers are thus forced into a position of either asking the State to purchase all of their slots or declining to accept subsidized children. This creates two types of facilities — those which serve federally-subsidized children and those which do not.

The staffing requirements further complicate child care in rural areas in which the number of centers is limited. Centers may choose not to serve federally-subsidized children rather than increase rates for all children. The alternative for federally-subsidized children is thus limited to available home-based care.

### Interpretation of requirements

A careful examination of the Federal requirements, as originally published, reveals they allow great latitude in interpretation. While the staff-child ratio has dominated public controversy, there is little problem in interpreting it. The ratio is a hard number, easily translated into cost and whether or not it is accomplished is easy to assess. Not so with many of the other requirements. It is far less easy to determine whether nonprofessionals are being used in productive roles to provide social services.

Three types of interpretation problems identified by the study are clar-

* Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin.

*William Darnell, director of research planning for Children's Television Workshop and a consultant for human services programs, was project manager for the study on which this article is based,* An Assessment of Barriers to Compliance with the Federal Interagency Day Care Requirements in Region V. *He was formerly president of Unco, Inc., a subsidiary of Kappa Systems, Inc. Susan Jones, senior analyst, Kappa Systems, was the principal analyst of the study. She also provided assistance in the implementation of the proposed strategy.*

ity, responsibility and current relevance. Examples of the problems are:

- *Clarity (from the Health and Nutrition Services Requirement): "The facility must provide adequate and nutritious meals and snacks prepared in a safe and sanitary manner. Consultation should be available from a qualified nutritionist or food service specialist."*

Ignoring what is meant by nutritious, safe and/or sanitary, the word "provide" has led to disagreement among States. In one case, this has been interpreted to mean that none of the children in a facility serving federally-subsidized children can bring a lunch from home, irrespective of the cost to parents. In another case, it has been determined that this would be acceptable.

- *Responsibility (from the Parent Involvement Requirement): "Whenever an agency (i.e., an operating or an administering agency) provides day care for 40 or more children, there must be a policy advisory committee or its equivalent at the administrative level where most decisions are made . . ."*

Administrative level is defined as "that level where decisions are made on the kind of programs to be operated, the hiring of staff, the budgeting of funds and the submission of applications to funding agencies." Is the formation of a policy advisory committee the responsibility of the administering agency, the day care center, or both? This requirement has typically been applied to centers and not to the administering agency.

- *Current relevance (from the Health and Nutrition Services Requirement): "Each child must receive dental, medical and other health evaluations appropriate to his age upon entering day care and subsequently at intervals appropriate to his age and state of health."*

A footnote to this requirement specifies that "Individual health evaluations and medical and dental care should be carried out only by highly qualified physicians and dentists." The 1968 requirements were developed prior to the general availability of paraprofessionals for health programs, such as Early and Periodic Screening, Diagnosis, and Treatment.

**Absence of guidance**

Despite the fact the Federal day care requirements were published almost eight years prior to this study and seven years prior to the enactment of Title XX, States have received no interpretation or guidelines for implementation or enforcement of the requirements.

One of the most fundamental barriers to implementation is not the requirements but rather the absence of Federal guidelines or assistance in interpreting them.

It would seem easy to point a finger at the Federal agency responsible for not providing much needed guidance, but it isn't. Until recently, there was no authority at the regional level to which States could direct questions about interpretations, monitoring expectations or specific audit requirements.

There is also no clear authority at the central office in Washington. While the Public Services Administration is responsible for enforcement of Title XX provisions for determining compliance, responsibility for interpretation of the requirements has not been clearly delineated between the Office of Child Development and the Public Services Administration. PSA has developed several versions of a guide for monitoring within the past year, yet OCD is the agency which is most often contacted for interpretation.

The problem is not unique to the region studied (Region V) nor is it unlike problems States are having in separating responsibility between the administration of social services and those units which set standards.

**History of the problem**

The method in which the standards were developed contributed to the problem. A special interdepartmental staff group from HEW, Labor, OEO and HUD was created and was responsible for developing the day care requirements in 1968. The Secretaries of the Departments of Labor and HEW, and the director of the Office of Economic Opportunity signed the requirements which applied to many programs in those three agencies. Thus, from the outset, the responsibility for providing assistance and clarification regarding the requirements was divided.

To further complicate matters, some of the agencies represented on the panel were subsequently disassembled or their responsibilities for administering day care were altered. For example, the Head Start Program was moved from the Office of Economic Opportunity to the Children's Bureau. The Children's Bureau was later dissected and its units, in large part, were divided between the Social and Rehabilitation Service and the Office of Child Development.

The result of this was that by the early 1970s the day care requirements had not been fully implemented or enforced by any agency. Further, a plan for implementation had never been created.

In 1973 and 1974 audits of the child day care programs by both HEW and GAO disclosed an astounding degree of noncompliance in day care facilities serving federally-subsidized children. Indeed, many facilities were not even in compliance with their own State's health and safety requirements. Clearly there were significant problems in adequately monitoring and enforcing both Federal and State requirements.

In 1975 Congress directed HEW to apply financial sanctions against States providing care to federally-subsidized children in facilities found to be out of compliance. Congress also directed the Secretary of HEW to evaluate the appropriateness of the requirements.

Title XX legislation gave PSA the responsibility for ensuring its day care requirements are met. This clarified the matter of monitoring and enforcement, except for one area — interpretation. The Office of Child Development assumed this responsibility as part of its role as the standard-setting agency for child care.

Congress eventually delayed implementation of the staff-child ratios under certain conditions until September 30, 1977 and made available $240 million in additional funds for child care.

During the early months of 1977,

PSA, with the cooperation of the Office of Child Development, produced a guide for monitoring day care for the States. The guide suggests interpretation for many of the requirements for providers. A similar guide for interpreting the requirements for the administering agency is currently being used. These efforts may minimize, but probably will not alleviate, the potential conflict that would undoubtedly develop between State and HEW auditors as they attempt to independently interpret the requirements.

**A possible strategy**

One strategy of operation in this interpretative limbo is currently being employed in Region V and involves an agreement between each State and the regional office on the interpretation of the requirements. The emphasis is on the similarities between the State standards and the Federal requirements.

Many States have put great effort into updating and revising their day care licensing requirements, and into working with the appropriate authorities for other State and local day care related codes (health, fire, etc.). Due in part to efforts in the early 1970s by the Office of Child Development in promoting model day care licensing standards and to the influence of the Federal requirements, every State in Region V has undergone a day care revision of standards since 1970.

Many of the Federal requirements may already be covered under the standards of each State, either in licensing codes or in social services or other administrative regulations. Therefore, the burden of the requirements, with the exception of the staff-child ratio, may be considerably less than generally believed. What is necessary is to first identify what the regulations are and then focus on the margin of difference rather than the requirements in their totality. The real difference is primarily ancillary services, which may be more appropriate requirements for the administering agency than for the provider. Examples of ancillary services which are Federal requirements are:

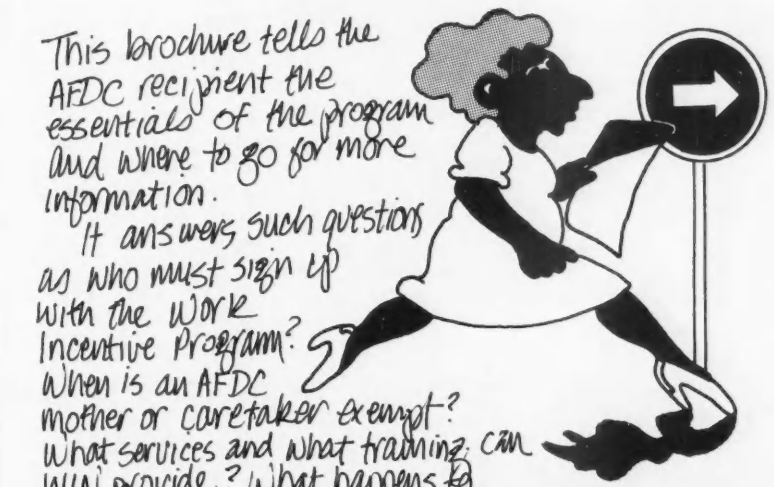
- Social services, such as counseling to families about day care and providing information and referral to community resources.
- Health and medical services.
- Training for day care operators and staff.

These are probably most effectively provided through existing delivery mechanisms rather than by day care providers, especially in the case of family day care. As noted earlier, responsibility for those requirements has not been clearly established, either within the Federal requirements or by Federal guideline.

An assumption basic to this State-Region strategy is that the State actually enforces its own standards. According to the SRS-sponsored *State and Local Child Day Care Management Study,* the diversity among monitoring and enforcement systems in the States is extraordinary. Most States can revoke the licenses of facilities which do not comply, a power totally lacking under the Federal requirements. Under Federal regulations, enforcement authority is limited to removing federally-subsidized children from inadequate facilities. The Federal requirements mean that a State should not receive Federal payment for a child in an ineligible facility, but they do not provide Federal authority to close a facility.

The basic premise of this approach is that existing State standards as well as monitoring and enforcement systems should be used to the extent possible and that Federal requirements should be necessary only when State standards are not adequate or are not enforced. ■

# WIN rules for the recipient


This brochure tells the AFDC recipient the essentials of the program and where to go for more information.
It answers such questions as who must sign up with the Work Incentive Program? When is an AFDC mother or caretaker exempt? What services and what training can WIN provide? What happens to the AFDC recipient who is required to sign up but fails to do so?

**Record**

*WIN and You* is available without cost in bulk from the Publications Distribution Office, Room G115-B, MES Building, OHD/HEW, Washington, D.C. 20201.

# Progress in the War on Medicaid Fraud

by Martin Judge, Editor

**"We have known for a long time that the best treatment for fraud and abuse is prevention, and the best prevention is efficient management."**

**Dr. M. Keith Weikel**

When the first phase of the war on Medicaid fraud and abuse ends in two years, the situation will be under control, says the nation's chief Medicaid official. But, cautions Dr. M. Keith Weikel, "Control should not be equated with eradication. However, we will definitely be managing the problem effectively rather than being managed by it."

Though the effort to curb Medicaid fraud and to see that the right persons get the right services began making headlines only recently, work to solve the problem began two years ago.

Despite this campaign, however, some estimates place the amount of loss due to fraud in 1976 between $750 million and $1.5 billion—about five to 10 percent of what is currently being spent on benefits. While this percentage of loss is not unheard of in business, when you add the dollars lost in providing services to ineligible patients and the cost of unnecessary services, it is substantial.

Since States have a dollar limit on their Medicaid funds, the money that is siphoned out of the system cannot

**"Just two of those convicted had defrauded the system out of $3.5 million–more than our office's first year budget."**

**Charles J. Hynes**

be replaced. Therefore, some low income citizens may be deprived of services.

**Genesis of the problem**

Although the campaign against fraud and abuse is expected to bring the problem under control in the near future, the haunting question remains: How did Medicaid get out of control in the first place and why did it take so long to begin reigning it in?

Undeniably, part of the answer is poor management. But the answer is more complex than that. When the Medicaid program was launched in January of 1966, the objective was to deliver comprehensive services on a scale that had never before been attempted. "It seems that inadequate attention was given to the fiscal controls on the delivery and the quality of the services," says Dr. Weikel, who in 1974 become commissioner of what was then SRS's Medical Services Administration.

"The objective in the early years of the program was to get the services to the people who needed them. The philosophy was: the more dollars you pour into the program, the more services are provided."

This theory did not meet serious challenge because it was recognized that it takes money to gear up any new program. Also helping to cloud the effectiveness of the program was that the number of recipients increased markedly each year as it was publicized. In addition, costs were expected to increase because more extensive services were being offered. Another major factor was that during the late 1960s and early 1970s medical costs began escalating generally.

But by 1974 the situation had changed. In that year there was only a two-percent increase in recipients of Medicaid benefits compared with a 15-percent increase in costs. "In 1974, we were spending $12.6 million on Medicaid," recalls Dr. Weikel, "and with that much money there had to be at least some fraud and abuse taking place. We began to look closely at the numbers. They didn't jibe, so we looked for the holes and began to find them."

An analysis by MSA showed that officials needed to shore up fiscal controls and expand their investigative activities. In an effort to gain public support for a "war on fraud and abuse," a press conference was held to explain the problem. Virtually no publicity resulted. Without public support for the war, knocking at the doors of law enforcement agencies, asking for a general crackdown, produced only hollow sounds.

There was not enough law enforcement muscle to go around. Both local and national law enforcement officials preferred to go after organized crime, drug traffic and other high-profile crime. In addition, information on the extent of fraud and abuse was sketchy. Why after all try to recover the $50 a pharmacist charged for undelivered drugs or the $20 from a physician who bills twice for the same visit? They simply are too time consuming to prove considering the amount to be recovered. The general feeling: Medicaid convictions are low-yield.

**"We are using the same techniques to fight Medicaid fraud and abuse as we have used in the past to fight official corruption."**

**Samuel Skinner**

**Emphasis on detection**

While continuing to advocate a crackdown on Medicaid rip-off artists, Medicaid officials began working on a system to help detect fraud and abuse by health care providers and recipients as well as honest errors in computation by Medicaid personnel.

"We have known for a long time that the best treatment for fraud and abuse is prevention, and the best prevention is efficient management," says Dr. Weikel. "To this end we developed an automated Medicaid Management Information System to permit States to handle legitimate claims more efficiently. The system also can alert State officials to questionable practices and identify the providers involved."

The first hurdle to accomplishing this objective was securing the cooperation of the States which operate individualized Medicaid programs under general Federal guidelines. To encourage them to install the computerized systems, Congress authorized payment of 90 percent of the setup cost of the systems and 75 percent of the on-going cost of operating them. To date 13 States are using the system and 19 more are working to install it.

The system can be programed to produce information in various forms. It can, for instance, identify physicians who perform an above average number of surgical procedures or clinical laboratory tests. It can also detect duplicate billing for the same service by comparing the types of services, date they were rendered and the cost on the invoices. The system can also detect other patterns of services such as the practice known as ping-ponging where a patient is referred back and forth from one medical practitioner to another.

When improper practices are suspected, a printout of the provider's claims is checked for unusual patterns, which may ultimately lead to an examination of the provider's records. Auditing the records is simplified by the information system because it has pinpointed the areas in which the suspected discrepancies lie.

A complicating factor in setting up an automated system is that each State, the District of Columbia and the territories have various types of computer systems, and the variation among them is substantial.

To assist the States in their fraud and abuse programs, HEW last year set up a 112-person Division of Fraud and Abuse Control. One of its primary responsibilities is to assess the system of each State and the effectiveness with which each system is being operated.

Assessment of a system determines whether or not the State has a proper mechanism for detecting fraud and abuse. If the State's capabilities or procedures are found to be deficient, staff provides counsel for effecting corrective action.

The second major responsibility of the Division of Fraud and Abuse Control is the comprehensive review of each State's policies and management practices. This takes from four to 12 weeks, depending on the size of the State. The review begins by drawing a sample of high-volume providers chosen from the State's lists of physicians, pharmacists, laboratories and nursing homes.

The team visits the providers' offices and checks their records for documents supporting claims. The audit includes such things as confirming that a charge for lab tests is backed up by a record of the test results. If there is a high number of claims which cannot be verified, the provider's file is turned over to the State for possible recovery of funds or prosecution.

If the team finds a high error rate across the board, it is a good indication that the guidelines for filling out claims are unclear. In that case the procedure for enrolling providers would be reviewed and suggestions presented for revising it.

To furnish on-going assistance to the States, MSA last year established the Institute for Medicaid Management which presents periodic seminars on a wide variety of management subjects and also consults with States as needed. Its mission is to identify and communicate the best technical and managerial practices to the States.

**Prosecutors crackdown**

While better detection techniques were being developed, there was a growing awareness of abuses and fraud by providers. In 1974, in the wake of reports by the news media of


## In a few words

This brochure outlines the new Child Support Enforcement program:
Who operates it.
Who is eligible.
How it works.
Where to apply.

**Record**

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widespread nursing home scandals, the State of New York appointed a special prosecutor for health and social services.

"The tactic of the nursing home industry is delay and stall, hoping we will go out of business so they can have business as usual," says Special Prosecutor Charles J. Hynes, who is also deputy attorney general for the State. But despite this stalling, Mr. Hynes has convicted 20 persons, indicted 53 more and is awaiting dispositions on an additional 30.

Asked if the cost of prosecution was justified by the funds recovered, Mr. Hynes said, "Just two of those convicted had defrauded the system out of $3.5 million—more than our office's first year budget." Mr. Hynes estimates that the nursing home industry in New York State has siphoned off about $70 million in Medicaid funds over the past five years.

Like New York, a number of States have added to or established investigative units to cover all aspects of Medicaid fraud.

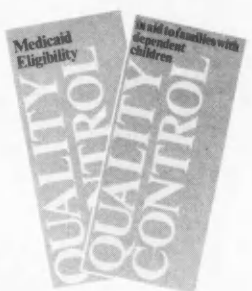
Recently, the Department of Justice has become a force in controlling fraud and abuse. "There has been a change at Justice in their attitude toward social programs in general since we began talking with them several years ago," says Dr. Weikel. "We had a very difficult time interesting U.S. attorneys in prosecuting, but now Justice is committing significant resources to the Medicaid effort."

One U.S. attorney who needed no encouraging was Samuel Skinner who has established a reputation for ferreting out fraud and abuse in health care in the Northern District of Illinois. Said Mr. Skinner: "We are using the same techniques to fight Medicaid fraud and abuse as we have used in the past to fight official corruption.

"In addition, we have been the first to use the Racket Influence and Corrupt Organization's Act in our efforts to combat fraud because of possible organized crime involvement. Included in the provisions of RICO are the possible forfeiture of various business enterprises, i.e. nursing homes, medical centers, pharmacies, which have been used by individuals defrauding Medicaid and Medicare."


# Are you accused of throwing money at the problem?

The real story is in this brochure which is designed to tell about the war being waged against errors by states and the Federal government.
The Quality control system involves continuous investigation of samples of medicaid claims, defects, apparent errors and recommends investigations and corrective action.

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*Quality Control in Aid to Families with Dependent Children* is available without cost


Why is such tough counterpunching required? Mr. Skinner feels one reason is that the program expanded too quickly to be managed effectively. Another, he says, is that everyone who wants to become a provider can do so without any screening and with only minimal licensing requirements.

Mr. Skinner says that a recent investigation of the nursing home industry in the Chicago area uncovered that it was a common practice for homes to receive kickbacks from pharmacies at the rate of three to six dollars per month for each public assistance patient. Seven nursing home owners were recently convicted of mail fraud and the receipt of kickbacks, and were fined $1 million collectively as well as sentenced to jail terms ranging from 60 to 90 days. In addition, six pharmacists were also convicted of paying kickbacks to nursing homes and were fined or incarcerated.

To combat such practices, Mr. Skinner established the first investigative unit in the U.S. whose sole function was to investigate fraud in various State and Federal social programs. Since August 1975, when the unit began operation, over 80 persons have been convicted of fraud and about $1.5 million have been recovered by the Government through restitution and fines.

In addition to an increased chance of being prosecuted, Mr. Skinner feels that penalties for so-called white-collar crime of this nature should be stiffened and has been testifying before congressional committees investigating the penalty structure.

"With the increased help from law enforcement agencies and with more and more States moving aggressively to control fraud and abuse, we will have it under complete control within two years," says Dr. Weikel. "And that's something we've never been able to say before." ■

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Public Health Service

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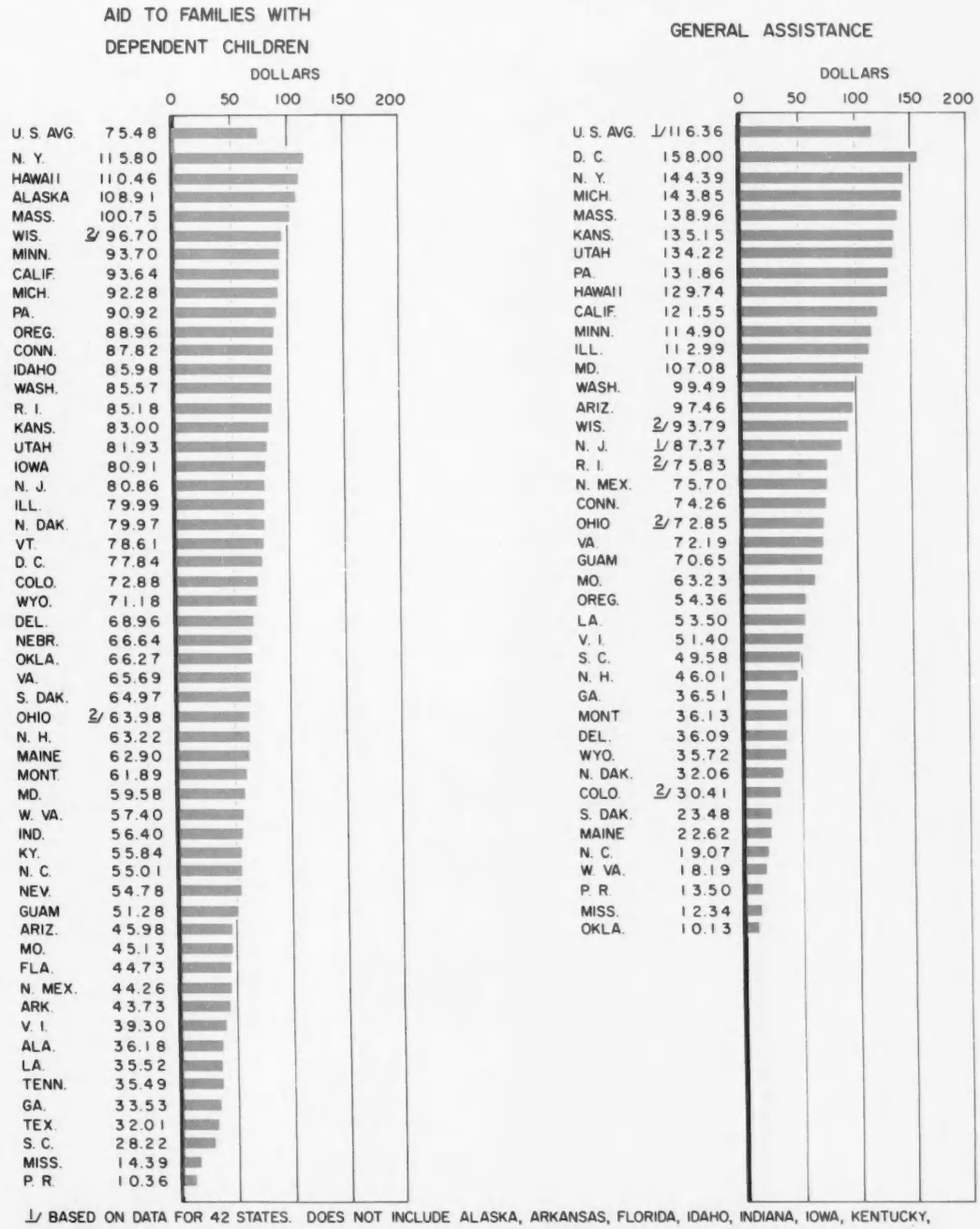


1/ BASED ON DATA FOR 42 STATES. DOES NOT INCLUDE ALASKA, ARKANSAS, FLORIDA, IDAHO, INDIANA, IOWA, KENTUCKY, NEBRASKA, NEVADA, TENNESSEE, TEXAS, AND VERMONT; DATA NOT REPORTED. NOT COMPUTED FOR ALABAMA; FEWER THAN 50 RECIPIENTS. DATA FOR NEW JERSEY INCLUDE ASSISTANCE TO THE WORKING POOR PROGRAM. 2/ ESTIMATED.

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